471-000-102 Form MC-9, "Prior Authorization Document," and Completion Instructions for IMD's

Use: Form MC-9 is used to prior authorize payment for IMD services for clients age 65 or older. Prior authorization may also be requested and issued with the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278). For instructions on submitting electronic transactions, see 471-000-50.

Each IMD admission or readmission requires a new Form MC-9 (or electronic authorization request). Approval for IMD services is granted only by Medicaid Division staff of Health and Human Services (HHS) Finance and Support.

For instructions on changing a prior authorization using Form MC-10, “Prior Authorization Document Adjustment,” see 471-000-211.

Completion: IMD facility staff complete Form MC-9 as follows -

2. Authorization Type: Check block 2, "Hospital."

3. Client Case Number: Enter the client's 11-digit Medicaid number on the top line. Enter the client's full name on the second line.

4. Medicaid Provider Number: Enter the provider's 11-digit Medicaid provider number, full name, and address.

5. Level of Care: Check block 6, "IMD."

8. Practitioner Name and License Number: Enter the full name of the certifying physician and the physician's license number.

10. ICD-9-CM Diagnosis Codes: This field is not completed by IMD staff. Medicaid Division staff will enter ICD-9-CM diagnosis codes based on the diagnosis descriptions in Field 17. Diagnosis codes on claims for IMD services are verified against codes on Form MC-9. The codes must match.

11. Medical Review Team Approval: This field is not completed by IMD staff. If approved, Medicaid Division staff checks "IMD" and signs or initials the line provided.

13. Admission Date: Enter the date of this admission to the IMD facility for which payment authorization is being requested.

15. Effective Date: Enter the "FROM" date. This is the first day of the authorized payment period. Enter the "TO" date, if appropriate. This is the first day for which payment is not authorized. For example, the day of discharge or death is not paid. Explain in field 16.

16. Additional Information: Enter the effective date of Medicaid eligibility. Enter the date Medicaid eligibility was determined, if the determination was made after this admission. Enter any information that may affect the authorized payment (e.g., explanation of Field 15 "TO" date, if present).

17. Diagnosis Description: Enter a brief narrative description of the client's medical diagnosis. The diagnosis requiring psychiatric treatment must be primary.

18. Signature Block: This field is not completed by IMD staff.

The facility submits the completed Form MC-9 with Form MC-14, “Confidential Report,” (For an example and explanation of Form MC-14, see 471-000-89) to –

HHS Finance and Support
Medicaid Division
P.O. Box 95026
Lincoln, NE 68509-5026

Review and Distribution:

If the authorization for IMD services is approved, the authorizing Medicaid Division staff will sign his/her full name and enter the date of approval in Field 18. One copy is retained in the Medicaid Division and one copy is sent to the facility. When submitting a claim to Nebraska Medicaid, the facility may attach a copy of the approved Form MC-9 to the initial claim. (The prior authorization document number must be entered on all claims for IMD services.)

If the authorization for IMD services is not approved, Medicaid Division staff will indicate rejection and return the unsigned Form MC-9 to the facility. Note: Prior authorization on Form MC-9 is not approved when findings on Form MC-14 are rejected by the Medicaid Division.

To view printable form click here: Prior Authorization Document

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

FORM MC-9
PRIOR AUTHORIZATION DOCUMENT

1. Document Number

2. ❑ 1. Drug ❑ 2. Hospital ❑ 3. Nursing Home ❑ 4. Home Health Agency/ Personal Care Guide Services/Therapies/ Hospital Outpatient ❑ 5. Practitioner ❑ 6. Dental ❑ 7. Health Supplies ❑ 8. Medically Handicapped Children

3. Client Case Number I.D. Number

Client Name

Payee Name (Optional)

4. Medicaid Provider Number

Name

Street

City State Zip Code

THIS AUTHORIZATION IS VOID IF CLIENT IS INELIGIBLE
Enter ONLY the information required for this authorization. Submit the white copy to the CENTRAL OFFICE immediately.

5. Level of Care (Check One)
❑ 1. Skilled ❑ 2. ICF ❑ 96. Ventilator ❑ 92. Swing Bed ❑ 5. Acute ❑ 6. IMD ❑ 7. ICF-MR

6. Rate/Total Amount
$

7.	CODE	NO.	RATE	DESCRIPTION OF SERVICE	AMOUNT
1	-				
2	-				
3	-				
4	-				
5	-				

8. Practitioner Name Practitioner License Number

9. ICD-9CM DIAGNOSIS CODES
Primary
Secondary
Primary Surgical Procedure Code

10. MR DIAGNOSIS CODE

11. Medical Review Team Approval
❑ 1. Skilled ❑ 92. Swing Bed
❑ 2. ICF ❑ 5. Acute
❑ 96. Ventilator ❑ 6. IMD
❑ 7. ICF-MR

12. RENTAL ITEMS

Purchase Cost	Initial Date
1. $	
2. $	
3. $	
4. $	
5. $	

13. Admission Date to Nursing Home (Mo. Day Year)

14. DM-5 Date (Mo. Day Year)

15. Effective Date From (Mo. Day Year) To (Mo. Day Year)

16. Central Office Approval
❑ YES ❑ NO

17. Additional Information

18. Diagnosis Description

19. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Department of Social Services. The Department of Social Services is not responsible for lost, stolen or damaged rental items.

Local/State Office

Sign Here ▸ Signature of Authorizing Agent

Date

20. Effective Date of Payment to Nsg. Home (Mo. Day Year)

MC-9 Rev.7/00 (12009)
(Previous version 2/86 should be used first)

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